emailed validation letter 9/23/09

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 9-9-09
Amount $1590

Ck# 02649

RECEIVED
SEP 09 2009
OFFICE OF INSPECTOR GENERAL

I. IDENTIFICATION

Name LP Pikeville, LLC d/b/a Signature HealthCARE of Pikeville

Address 260 South Mayo Trail

City/County/Zip Pikeville, Pike, 41501

Telephone number 606-437-7327 admin.Pike@shccs.com + hdelker@shccs.com

Administrator Elaine Jones

Date facility operation began at current address _____

Date facility began operation under current owner 11/01/2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	106	106
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	**Profit** ✓	Individual
County	Nonprofit	Partnership
City		Corporation
Private ✓		LLC ✓

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.
N/A

(OVER)

9/30

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Pikeville, LLC

Address of corporation 2979 PGA Blvd., Palm Beach Gardens, Fl 33410

President or Chairman N/A

Vice President N/A

Secretary/CEO N/A

Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility. None

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation. None.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner. None

Name and address of Parent Corporation and/or management company, if applicable.

Parent	Management Company
LP O Holdings, LLC	**Signature Consulting Services, LLC** **Signature Clinical Consulting Services, LLC**
2979 PGA Blvd	2979 PGA Blvd
Palm Beach Gardens, Fl 33410	Palm Beach Gardens, Fl 33410

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative	Title	Date
	CFO	9-4-09

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)